United States Department of Labor
Employees' Compensation Appeals Board

P.W., Appellant	)	
and	)	**Docket No. 15-0716**
	)	**Issued: June 21, 2016**
U.S. POSTAL SERVICE, POST OFFICE, Arlington, WA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On February 2, 2015 appellant filed a timely appeal from a January 9, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation effective July 27, 2014; and (2) whether appellant has met her burden of proof to establish continuing work-related disability after the July 27, 2014 termination of her compensation benefits.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 30, 2005 appellant, then a 35-year-old rural carrier associate, filed an occupational disease claim (Form CA-2) alleging an injury to her right shoulder, arm, and hand as a result of extending and reaching at work. She stopped work on September 29, 2005. Thereafter appellant accepted a part-time limited-duty job on October 7, 2005. OWCP accepted the claim for right shoulder impingement, right arm radiculitis, right shoulder and upper arm sprain with superior glenoid labrum lesion, and right rotator cuff fraying.

On April 6, 2007 appellant underwent right shoulder arthroscopic repair full-thickness rotator cuff tear, subacromial decompression and acromioplasty, lysis of adhesions and manipulation, repair of type 2 superior labrum anterior-posterior (SLAP) lesion, anterior capsulorraphy, and debridement of glenohumeral joint. On June 22, 2007 she underwent right shoulder arthroscopic repair full-thickness rotator cuff tear of infraspinatus, subacromial decompression, lysis of adhesions and manipulation, revision resection of distal clavicle, anterior capsulorraphy and labral repair, and debridement of glenohumeral joint. On January 18, 2008 appellant underwent right shoulder arthroscopic subacromial decompression and acromioplasty, lysis of glenohumeral joint adhesions, and manipulation. OWCP authorized these surgeries. Appellant received wage-loss compensation and was placed on the periodic compensation rolls beginning August 3, 2008.[2]

In an August 6, 2013 work capacity evaluation, Dr. Phillip O. Smith, a family practitioner and attending physician, advised that appellant could work eight hours daily with restrictions that he termed as "indefinite." He limited the use of her right arm advising that she could not lift her right arm. Dr. Smith indicated that appellant was "fixed and stable but really needs retraining to qualify her for a job she can do."

On September 11 and October 3, 2013 OWCP referred appellant to Dr. Ronald Teed, a Board-certified orthopedic surgeon, for a second opinion regarding whether she continued to have any work-related residuals and/or restrictions.

In an October 28, 2013 report, Dr. Teed described appellant's history and treatment. On examination appellant had complaints of sharp, stabbing right shoulder pains that radiated up into the right side of the neck and anterior right chest wall. She reported that she could not lift her arm up to or above shoulder level secondary to shoulder pain. Dr. Teed related that appellant believed that her pain was quite disabling and she was unable to work at all. His examination revealed that her pain demonstration was tender diffusely over the right shoulder and anterior chest walls up into the right paraspinous musculature, although he noted that it was somewhat inconsistent. Dr. Teed noted that sometimes appellant was extremely tender in one spot, but not

[2] Appellant did not work after April 6, 2007. She received a November 17, 2010 schedule award for 30 percent permanent impairment of her right arm. In a July 17, 2010 report, Dr. Michael Coe, a Board-certified orthopedic surgeon and a second opinion physician, advised that, while appellant had some chronic residual shoulder pain, it was difficult to evaluate her work capacity due to pain behavior. He indicated that she could work full time within restrictions. On May 13, 2011 OWCP noted that appellant was referred to vocational rehabilitation on March 17, 2011. However, on April 13, 2011 the vocational rehabilitation counselor determined that appellant could not perform sedentary work due to her restrictions.

at other times. Appellant had active range of motion of the right shoulder of 0 to 30 degrees with forward flexion and abduction. Dr. Teed noted that she pulled quite firmly against him when trying to bring the arm into any passive range of motion. His diagnoses included resolved right shoulder strain/sprain, right shoulder impingement, and resolved right arm radiculitis. Dr. Teed also diagnosed unrelated conditions that included right acromioclavicular degeneration, chronic degenerative disc disease and spondylosis of the cervical spine without central canal foraminal stenosis, chronic lumbar spine degenerative disc disease and spondylosis, and pain behavior and symptom magnification. He opined that he found no residuals from appellant's work-related and approved injuries. Dr. Teed explained that her examination was dominated by pain behavior and the findings were inconsistent and subjective. He added that he "did not find any objective signs other than [appellant] pulls against me when trying to examine the shoulder in active assist in just about any motion I go with the shoulder." Dr. Teed completed a work capacity evaluation and indicated that she was capable of performing her usual job.

In a December 14, 2013 report, Dr. Smith noted that he reviewed Dr. Teed's report and he concurred with "his history, exam[ination], and diagnostic conclusions including that [appellant's] shoulder problems are work related and her spinal problems not clearly work related." He added that she was "fixed and stable for at least 2 years, and has not been receiving curative therapy in that time." Dr. Smith noted examining appellant more than 15 times in the last five years. On each examination appellant revealed "dramatic limitation in her forward flexion and abduction, with limitation of 30 to 40 degrees each time. There has been almost no variability in this finding. [Appellant] cannot lift her arm." He advised that appellant could perform "many types of work, but cannot and will never be able to work in [the employing establishment] as all the work at the [employing establishment] required lifting of the right arm to the shoulder level." Dr. Smith noted that Dr. Teed found only 30 degrees of forward flexion. He opined that it was "difficult" for him to see how appellant could work for the employing establishment as "she needs retraining."

On February 5, 2014 OWCP found that Dr. Teed's report created a conflict with the opinion of Dr. Smith regarding the nature and extent of any ongoing residuals and disability.

On February 18, 2014 OWCP referred appellant along with a statement of accepted facts and the medical record to Dr. Anthony Woodward, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve the conflict in opinion between Drs. Teed and Smith.

In a March 20, 2014 report, Dr. Woodward noted appellant's history. He examined the cervicothoracic area and found tenderness in the right trapezius, but nowhere else. Dr. Woodward measured active range of motion of both shoulders and noted that appellant had "insufficient elevation to allow measurement of rotation of the right shoulder." Left arm muscle strength was normal while the right arm had "give-way weakness of shoulder abduction and reduced strength of shoulder flexion and elbow flexion because of pain." The other muscle groups were normal. Appellant had tenderness over the entirety of the right shoulder region and no left shoulder tenderness. Dr. Woodward diagnosed right shoulder girdle muscle strain, long resolved; and right shoulder Buford complex, an anatomic variant, congenital or developmental, preexisting, unrelated, possibly treated as a SLAP 2 tear. Appellant was times three postoperative acromioplasty right shoulder and distal clavicle excision without clinical benefit, unrelated. Dr. Woodward also opined that the report of repair of rotator cuff tears were not

documented by magnetic resonance imaging (MRI) scan or arthrogram and were without clinical benefit and unrelated. An arthroscopic repair of anterior capsule times two was also without clinical benefit and unrelated as it was not noted on MRI scan testing. Dr. Woodward noted that there was no orthopedic explanation for chronic right shoulder pain and stiffness. He opined that appellant's report of neck pain was unrelated to the work event. Dr. Woodward also advised that she had psychosocial issues that were unrelated and not assessed. He explained that the medical records over the years consistently reported right shoulder range of motion loss. These repeated similar findings over many examinations were considered to be objective findings. However, Dr. Woodward advised that "there is no orthopedic explanation for this stiffness. The diagnosis of adhesive capsulitis or frozen shoulder has been made, but the examinee has had three operations and years of physical therapy without success, making that diagnosis unlikely." Dr. Woodward also indicated that the episode "of catching falling mail is not expected to cause a significant or prolonged injury to the right shoulder region. The activity of delivering and collecting mail for eight or nine hours per week for a few weeks is not expected to cause prolonged problems, which persist after that activity has been stopped." He advised that later independent medical evaluations all reported pain behavior and guarding, which did not allow an orthopedic anatomic explanation for appellant's symptoms and findings. Dr. Woodward advised that appellant's work activities of extending the arm and reaching might cause right shoulder girdle muscle pain, but noted that appellant "has not performed that activity, it seems, since September 30, 2005. That is nine and one-half years ago. That activity, therefore, cannot be considered the cause of the examinee's current right shoulder symptoms and findings." Dr. Woodward did not attribute any current right shoulder girdle condition to work activities. He explained that he had "no orthopedic explanation for the examinee's current symptoms and findings. Assuming the symptoms and finding are valid, the examinee can perform work activities with the exception of limitation of the use of the right arm, which she can use for activities below shoulder level. I do not attribute these restrictions to any work activity."

On June 3, 2014 OWCP proposed to terminate appellant's wage-loss compensation based on the opinion of Dr. Woodward.

In a July 18, 2014 report, Dr. Smith noted reviewing Dr. Woodward's report. He indicated that appellant's work history included extensive work with her right arm above shoulder level. Dr. Smith explained that all of her symptoms started after the traumatic work event and had not remitted. He noted that, while Dr. Woodward opined that appellant did not have adhesive capsulitis because she did not respond to surgery, he "disputed this" as it was "common for adhesive capsulitis not to respond to surgery." Dr. Smith asserted that this was "slim evidence" on which to find that her injury was not work related. He explained that there was compelling evidence that her injury was work related. Dr. Smith indicated that he had noted in his reports for several years that appellant was "fixed and stable, limited in her activities" and "in need of no further medical treatment, but in need of retraining." He recommended that OWCP support a retraining effort.

In a July 22, 2014 decision, OWCP terminated appellant's wage-loss compensation benefits effective July 27, 2014. It found that the weight of the medical evidence rested with Dr. Woodward and supported that appellant no longer had any disability from work stemming from the accepted work-related conditions. Appellant was advised that the decision did not affect her entitlement to medical care for the work-related conditions.

On September 19, 2014 appellant's then representative requested reconsideration and submitted additional evidence. In a September 12, 2014 report, Dr. Thomas Stark, a Board-certified orthopedic surgeon, noted reviewing three right shoulder x-rays from September 11, 2014, which revealed postoperative changes with significant acromioplasty and aggressive distal clavicle resection. There were no acute fractures or dislocations. Dr. Stark diagnosed postoperative changes with aggressive distal clavicle resection and acromioplasty and otherwise normal x-rays. On the right shoulder examination appellant exhibited guarding. Dr. Stark noted that appellant had had extensive physical therapy without relief. He indicated that, while in pain management, appellant was prescribed large quantities of oxycodone and it was worrisome that several drug tests were negative for oxycodone. Dr. Stark determined that appellant had significant pain with probable symptom-magnification and very poor range of motion. He diagnosed Type I SLAP lesion with acromioclavicular arthritic changes; adhesive capsulitis, current (or postoperative arthrofibrosis with poor motion); Type II SLAP lesion, historic; rotator cuff tear including rotator interval tear, supraspinatus and infraspinatus tears, historic, and chronic pain. Dr. Stark also diagnosed cervical radiculitis and depression but indicated they were not work related. He opined that the postoperative arthrofibrosis and chronic pain were a direct result of the approved surgeries. Dr. Stark noted that as they were complications of the previous surgeries, they were related to the claim. He indicated that he concurred with Dr. Woodward except for his statement that appellant's current disability was not related to the claim. Dr. Stark explained that, while some of the surgeries were ill advised, this did not change the fact that appellant was continuing to have significant symptoms and disability as a result of the surgeries. He indicated that her current pain and decreased function was secondary to an essentially nonfunctioning shoulder disabled her from her date-of-injury position as she "clearly cannot perform the essential duties of her job as she has no ability to do the repetitive lifting, reaching, and pulling required of the job." Dr. Stark continued to treat appellant.

In a letter dated October 31, 2014, OWCP requested that Dr. Woodward review the new medical evidence and address whether appellant was capable of performing her duties as a rural carrier associate and whether the new medical evidence altered his opinion.

In a December 26, 2014 addendum, Dr. Woodward responded that he had reviewed the new medical evidence subsequent to his previous review of the record. He explained that the diagnosis of adhesive capsulitis was "unlikely" not only because shoulder stiffness had persisted after three operations, but also after years of physical therapy. Dr. Woodward indicated that Dr. Smith was correct that the absence of benefit from treatments did not rule out a diagnosis, but he explained that the natural history of primary frozen shoulder or adhesive capsulitis was one of improvement over the years whatever treatment was provided. He concluded that appellant's history was inconsistent with the usual pattern of frozen shoulder. Dr. Woodward determined that appellant's consistent presentation of stiffness of the right shoulder was inconsistent with the duties of a rural carrier associate and he did not attribute her right shoulder condition to any work-related activity. He reviewed the new report from Dr. Stark and explained that it confirmed his history and the results of his examination. Dr. Woodward explained that Dr. Stark attributed the shoulder stiffness to arthrofibrosis secondary to the three latest operations to appellant's shoulder, but he did not attribute the necessity of those operations to a work event, as far as he could tell. He indicated that Dr. Stark's consultation made no difference to the opinions expressed in his independent evaluation.

By decision dated January 9, 2015, OWCP denied modification of its prior decision.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[3] Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[4]

Section 8123(a) of FECA provides, in pertinent part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[5] Where a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[6]

ANALYSIS -- ISSUE 1

OWCP accepted that appellant sustained right shoulder impingement, right arm radiculitis, right shoulder and upper arm sprain with superior glenoid labrum lesion, and right rotator cuff fraying. As previously noted, appellant underwent three separate right shoulder surgeries to include arthroscopic repairs on April 6 and June 22, 2007 and January 18, 2008.[7] The Board notes that these surgical procedures were authorized by OWCP.

OWCP developed the claim and determined that a conflict of medical opinion existed between Dr. Teed, the second opinion physician, who found that appellant could perform her usual job and Dr. Smith, the treating physician, who indicated that the accepted conditions were fixed and stable, but that appellant could not perform office work and needed retraining. Therefore, it properly referred appellant to Dr. Woodward, a Board-certified orthopedic surgeon, for an impartial medical examination to resolve the conflict.

In a March 20, 2014 report, Dr. Woodward noted appellant's history and examined appellant. His findings included tenderness in the right trapezius, but nowhere else. Dr. Woodward noted shoulder range of motion and found "give-way weakness" with right shoulder abduction and reduced strength of shoulder flexion and elbow flexion because of pain. He diagnosed a long resolved right shoulder girdle muscle strain; and a nonwork-related right

[3] *Curtis Hall*, 45 ECAB 316 (1994).

[4] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[5] 5 U.S.C. § 8123(a); *see also Raymond A. Fondots*, 53 ECAB 637 (2002); *Rita Lusignan (Henry Lusignan*, 45 ECAB 207, 210 (1993).

[6] *See Roger Dingess*, 47 ECAB 123, 126 (1995); *Juanita H. Christoph*, 40 ECAB 354, 360 (1988); *Nathaniel Milton*, 37 ECAB 712, 723-24 (1986).

[7] Appellant stopped work following her surgery on April 6, 2007.

shoulder Buford complex that was congenital or developmental and preexisting. Dr. Woodward noted that appellant had three right shoulder acromioplasty and distal clavicle excisions without clinical benefit and opined that these were not employment related. He advised that the report of repair of rotator cuff tears were not documented by MRI scan or arthrogram and were without clinical benefit and unrelated. Dr. Woodward indicated that two arthroscopic repairs of the anterior capsule also without clinical benefit and unrelated based on MRI scan testing, as there was no orthopedic explanation for chronic right shoulder pain and stiffness. Furthermore, he observed that the adhesive capsulitis or frozen shoulder was diagnosed, but that appellant "has had three operations and years of physical therapy without success, making that diagnosis unlikely." Dr. Woodward noted that "delivering and collecting mail for eight or nine hours per week for a few weeks is not expected to cause prolonged problems, which persist after that activity has been stopped." He also noted that appellant had not performed such work activities for over nine years. Based on this, Dr. Woodward opined that such activities "cannot be considered the cause of the examinee's current right shoulder symptoms and findings." He found "no orthopedic explanation" for appellant's current symptoms and that she could "perform work activities with the exception of limitation of the use of the right arm, which she can use for activities below shoulder level." He opined that her restrictions were not attributable to any work activity.

The Board finds that Dr. Woodward's opinion cannot be given special weight as his report is based upon an improper factual background. The Board finds that OWCP improperly deferred to Dr. Woodward's March 20 and December 26, 2014 opinions. The Board notes that he did not consider the accepted conditions and surgeries that OWCP authorized. Although the conditions accepted by OWCP included rotator cuff fraying, Dr. Woodward asserted that rotator cuff tears were undocumented and not employment related. He suggested that all of her authorized surgeries were not work related. However, any disability or impairment resulting from an OWCP authorized surgery is compensable.[8] Furthermore, a medical expert should only determine the medical question certified to him. Determination of the legal standards in regard to such medical questions is outside the scope of his expertise.[9] Where it appears that the expert is applying an erroneous standard for compensability, his opinion loses probative value.[10] The Board finds that as his report was not based on an accurate factual background, it cannot be given special weight and is insufficient to resolve the conflict in the medical evidence.[11] Thus, there remains an unresolved conflict regarding the nature and extent of any ongoing residuals and disability.[12] Therefore, OWCP cannot be found to have met its burden of proof to justify termination of appellant's wage-loss compensation benefits.

[8] *Rose M. Thompson*, 33 ECAB 1947 (1982).

[9] *Barbara Bush* , 38 ECAB 710 (1987).

[10] *Jeannine E. Swanson*, 45 ECAB 325 (1994); *John A. Snowberger*, 34 ECAB 1262 (1983).

[11] *See D.C.*, Docket No. 12-1905 (issued July 25, 2013).

[12] In light of the Board's finding on the first issue, the second issue is moot.

CONCLUSION

The Board finds that OWCP improperly terminated appellant's wage-loss compensation effective July 27, 2014.

ORDER

IT IS HEREBY ORDERED THAT the January 9, 2015 decision of the Office of Workers' Compensation Programs is reversed.

Issued: June 21, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board